U.S. Department of Labor

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Issue Date: 08 March 2004

CASE No.: 2003-BLA-00042

In the Matter of

RICHARD F. DEETER
Claimant

v.

HEGINS MINING COMPANY
Employer

and

LACKAWANNA CASUALTY COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

HELEN M. KOSCHOFF, Esquire
For Claimant

WILLIAM E. WYATT, Esquire1
For Employer

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS ON MODIFICATION

1 On October 15, 2003, counsel for Employer withdrew as representative. No substitution of counsel was filed before this Decision and Order was issued.

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[2]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On November 5, 2002, this case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing. DX-60. The hearing was held before me in Reading, Pennsylvania, on June 4, 2003, at which time the parties had full opportunity to present evidence and argument. This decision is based on an analysis of the record, the arguments of the parties, and the applicable law. At the hearing, Claimant's Exhibits 1-21, Director's Exhibits 1-62 and Employer's Exhibits 1-10 were identified and received into the record, with leave granted for the submission of additional exhibits.[3] Hearing Transcript at 7, 16-17.

ISSUES

The following specific issues are presented for adjudication:

1. Whether Claimant suffers from pneumoconiosis.
2. Whether Claimant's pneumoconiosis was caused by his coal mine employment.
3. Whether Claimant suffers from a totally disabling pulmonary or respiratory impairment.
4. Whether Claimant's total respiratory disability is due to pneumoconiosis.
5. Whether Claimant has proven a change in conditions or mistake in determination of fact.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

On June 23, 1999, Richard F. Deeter ("Claimant") filed his initial claim for benefits under the Act. DX-1. This claim was initially denied by the Office of Workers' Compensation

[2] The adjudication of this claim is subject to regulations as amended effective January 19, 2001. 20 C.F.R. § 718.2 (2001). Unless otherwise indicated, citations are to the regulations as amended. Because this claim was "pending" on January 19, 2001, the provisions of the amended regulations that limit the development of medical evidence do not apply to the consideration of Claimant's petition for modification. *See* 68 Fed. Reg. 69935 (Dec. 15, 2003).

[3] In this Decision and Order, "CX" refers to Claimant's Exhibits; "DX" refers to Director's Exhibits; and "EX" refers to Employer's exhibits.

Programs ("OWCP") on September 16, 1999. DX-14. On December 10, 1999, this first claim was referred to the Office of Administrative Law Judges for a formal hearing. DX-23. The claim was remanded to the District Director on March 30, 2000, for a determination of the financial status of the first named responsible coal mine operator, DX-33, and on September 29, 2000 was again referred to this Office for a formal hearing. DX-39. After a formal hearing was conducted on March 29, 2001, DX-43, this claim was denied by an administrative law judge on November 1, 2001. DX-44.

Claimant appealed to the Benefits Review Board. On February 19, 2002, Claimant moved to remand the claim in order to seek modification. DX-50. The Board dismissed the appeal on March 18, 2001. DX-51. Claimant filed his petition for modification with the District Director on July 25, 2002. DX-53. The District Director denied Claimant's modification petition in a proposed decision and order issued on September 5, 2002. DX-56. Claimant then requested a formal hearing before OALJ, and the claim was forwarded for adjudication.

B. Factual Background

Claimant was born on May 3, 1939. DX-1. On May 18, 1968, he married Carol Umlauf and they remain together. DX-1. Hearing Transcript at 18. Claimant has no other dependents for purposes of augmentation of benefits under the Act.

Claimant testified at the formal hearings on the original claim, conducted on March 29, 2001, DX-43, and for the instant modification proceedings, which hearing was conducted on June 4, 2003.

At the first hearing, Claimant testified that he had worked in the mines for 25 years underground, and then completed his coal mine employment as a hoisting engineer for an additional three years.[4] DX-43 at 9-11. As a hoisting engineer, Claimant was responsible for hoisting coal from the mine and at times load the truck, and at times pick some rock and send timber into the mine as needed. He said that his last employment would require him to lift and carry heavy timber weighing 100 lbs. or more. DX-43 at 12. Mr. Deeter reported that he had experienced breathing problems since 1994, which have become progressively worse. DX-43 at 12-14. He testified that he had seen two doctors for separate medical problems ─ Dr. Lupold and Dr. Kraynak.

At the current hearing, Claimant testified that his breathing condition has worsened, that he continues to see Dr. Kraynak about every three months, and that his activities are limited. Hearing Transcript at 18-21.

At the first hearing, the parties stipulated that Claimant had participated in coal mine

[4] The entirety of Claimant's coal mine employment took place in the Commonwealth of Pennsylvania. This claim therefore arises within the jurisdiction of the United States Court of Appeals for the Third Circuit. *See Broyles v. Director*, *OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998); *Kopp v. Director, OWCP*, 877 F.2d 307, 12 BLR 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 BLR 1-200 (1989) (*en banc*).

employment for 28 ½ years. In his Decision and Order issued November 6, 2001, Judge Brown found that the stipulation was supported by the record. DX-44. I accept Judge Brown's determination, and find that the issue of Claimant's coal mine employment is not contested.

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits shall be evaluated under the Part 718 standards. 20 C.F.R. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant must prove that (1) he has a history of coal mine employment; (2) that he has pneumoconiosis; (3) that pneumoconiosis arose out of his coal mine history; (4) that he is totally disabled and (5) that his total disability is due to pneumoconiosis. Claimant has the burden of proving each element of entitlement to benefits by a preponderance of the evidence. *Director*, *OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 18 BLR 2A-1 (1994), *aff'g* . *Greenwich Collieries v. Director*, *OWCP*, 990 F.2d 730, 17 BLR 2-64 (3d Cir. 1993). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 BLR 1-111 (1989); *Perry v. Director*, *OWCP*, 9 BLR 1-1 (1986) (*en banc*).

This claim involves Claimant's petition for modification. The Benefits Review Board has held that a change in conditions is established when the determination is made that the weight of the new evidence, considered in conjunction with the previously submitted evidence, is sufficient to establish the elements of entitlement which were not met in the prior decision. *Kingery v. Hunt Branch Coal Co*., 19 BLR 1-6 (1994); *Nataloni v. Director*, *OWCP*, 17 BLR 1-82 (1983). In order to consider whether a claimant has established a mistake in determination of fact, I must review the record as a whole. The U.S. Court of Appeals for the Third Circuit has held that, on modification, "the [ALJ] must review all evidence of record - any new evidence submitted in support of modification as well as the evidence previously of record - and 'further reflect' on whether any mistakes [of] fact were made in the previous adjudication of the case." *Keating v. Director, OWCP*, 71 F.3d 1118; 20 BLR 2-53 (3d Cir. 1995).

In his Decision and Order of November 4, 2001, Judge Brown found that Claimant failed to establish the existence of pneumoconiosis or disability related to a pulmonary impairment. DX-44. Accordingly, I must review the record to determine if Claimant has experienced a change in conditions or if a mistake of fact was made in the previous adjudication.

D. Medical Evidence of Record

The pertinent medical evidence of record, including that which was submitted with the original claim, is set forth below.[5]

[5] This decision is based on a *de novo* review and consideration of the entire record. Nevertheless, not all of the evidence that was submitted prior to the instant request for modification, and which was specifically listed in prior decisions on the original claim, may necessarily be set forth herein except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n. 3 (8th Cir. 2000).

X-Ray Evidence

The record contains the following X-ray evidence:

X-Ray Evidence submitted for Modification

Ex. No.	X-Ray Date	Date of Reading	Physician	Credentials	ILO Class.
CX-6	03-20-2003	03-24-2003	Smith	B/BCR	1/0
CX-15	03-20-2003	04-25-2003	Capiello	B/BCR	1/0
CX-17	03-20-2003	04-29-2003	Miller	B/BCR	1/0
EX-3	03-20-2003	05-12-2003	Ciotola	B/BCR	0/0
EX-1	03-28-2003	03-28-2003	Ciotola	B/BCR	0/0
EX-5	03-28-2003	05-19-2003	Duncan	B/BCR	0/0
EX-10	03-28-2003	06-10-2003	Sundheim	B/BCR	0/0
CX-23	03-28-2003	06-19-2003	Ahmed	B/BCR	1/1
CX-23	03-28-2003	06-20-2003	Miller	B/BCR	1/1
CX-23	03-28-2003	06-25-2003	Capiello	B/BCR	1/2

X-Ray Evidence submitted with Original Claim

Ex. No.	X-Ray Date	Date of Reading	Physician	Credentials	ILO Class.
DX-10	08-11-1999	08-11-1999	Kraynak	n/a	1/1
DX-11	08-11-1999	09-10-1999	Barrett	B/BCR	negative
DX-25	08-11-1999	02-12-2000	Mathur	B/BCR	1/1 “overexposed”
DX-26	08-11-1999	01-03-2000	Ahmed	B/BCR	1/1
DX-26	08-11-1999	01-07-2000	Pathak	B	1/2
DX-26	08-11-1999	01-10-2000	Miller	B/BCR	1/1
DX-26	08-11-1999	01-17-2000	Cappiello	B/BCR	1/2, em, copd

DX-41	08-11-1999	10-25-1999	Wheeler	B/BCR	0/0
DX-41	08-11-1999	10-25-1999	Scott	B/BCR	0/0
DX-42	11-12-1999	01-03-2001	Smith	B/BCR	1/0
DX-42	11-12-1999	02-25-2001	Brandon	B/BCR	1/1
DX-41	11-12-1999	01-21-2000	Scott	B/BCR	0/0
DX-41	11-12-1999	01-21-2000	Wheeler	B/BCR	0/0

Medical Opinions submitted for Modification

Medical conclusions are relevant both to the diagnosis of coal workers' pneumoconiosis at 20 C.F.R. § 718.202(a)(4) and to the determination of the presence of a totally disabling pulmonary or respiratory impairment at 20 C.F.R. § 718.204(b)(2)(iv). The findings of a physician in either instance must be supported by a reasoned medical opinion. *See* 20 C.F.R. §§ 718.104(d), 718.204(a)(4), 718.204(b)(2)(iv).

The qualifications of physicians are relevant to my assessment of the probative value of their opinions. *See generally Collins v. J&L Steel (LTV Steel)*, 21 BLR 1-181 (1999); *Clark v. Karst-Robbins Corp.*, 12 BLR 1-149 (1989)(*en banc*); *Lucostic v. United States Steel Corp.*, 8 BLR 1-46 (1985). Dr. Smith has served as an Assistant Clinical Professor at Schools of Osteopathic Medicine in Philadelphia and New York. Dr. Capiello was an Assistant Professor of Radiology at the Albert Einstein College of Medicine from September 1, 1982 to September 1, 1984. CX-16. Dr. Miller is also an Assistant Clinical Professor of Radiology, College of Physicians & Surgeons, Columbia University. CX-18. Dr. Sundheim's resume reflects that he is a "Clinical Assistant Professor," Department of Radiology, Temple University School of Medicine. EX-10. Dr. Wheeler is board certified in radiology and is a "B reader." He has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Wheeler has been an Associate Professor of Radiology since 1974, and prior to that an assistant professor of radiology since 1969. DX-41 [EX-28]. Dr. Scott is board certified in radiology and is a "B reader." He has held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Scott has been an Associate Professor of Radiology since 1984, and prior to that an assistant professor of radiology since 1978. DX-41 [EX-28].

The medical opinions submitted on modification are set forth here, with medical opinion evidence introduced with the original claim set forth below.

Dr. Raymond J. Kraynak

On July 26, 2002, Dr. Kraynak submitted a brief letter report in support of Claimant's request for modification. DX-55. He noted that Claimant had been under his care for several years, and that Mr. Deeter has exhibited increasing complaints of chronic shortness of breath,

productive cough and exertional dyspnea.[6] Dr. Kraynak documented the results of pulmonary function tests administered on July 16, 2002, as showing "an FEV1 of 31.40%, FVC 67.74% and MVV 33.18% predicted." He concluded that Claimant's condition had worsened, and that he "continues to be totally and permanently disabled, secondary to Coal Workers' Pneumoconiosis, contracted during his employment in the anthracite coal industry."

Dr. Kraynak prepared a medical report dated March 31, 2003, that included his observations of Claimant while under his care since August 11, 1999. CX-10. The doctor recorded consistent complaints of shortness of breath, productive cough and exertional dyspnea. The doctor relayed Claimant's complaints that he had difficulty walking one-half to one blocks or up several steps without becoming short of breath. Claimant also had presented with complaints of a morning productive cough.

A coal mine employment history of 27 years was referenced in the preparation of this report and Dr. Kraynak's conclusions. Dr. Kraynak reviewed the results of pulmonary function testing, dated March 20, 2003, which "revealed an FEV1 of 52.28%, FVC 55.71% and MVV 48.27% predicted," as well as Dr. H. K. Smith's positive interpretation of a March 20, 2003 X-ray.

On physical examination, Dr. Kraynak detected a "[m]ild increase in AP diameters; scattered wheezes in all lung fields; no rales or rhonchi auscultated." He saw no edema in Claimant's extremities. Dr. Kraynak concluded:

> Based upon [Claimant's] history of having worked in the anthracite coal industry in excess of 10 years, the complaints with which he has presented, my physical examination and the diagnostic studies performed, it is my opinion that he is totally and permanently disabled, secondary to Coal Workers' Pneumoconiosis, contracted during his employment in the anthracite coal industry. He is unable to lift, carry, climb steps or walk for any period of time. He must be able to sit, stand and lay at his leisure, secondary to his severe respiratory impairment.

These findings were discussed in his most recent deposition, taken on May 9, 2003. CX-19 at 10-11. Based on his continuing care and treatment of Claimant, Dr. Kraynak opined that Mr. Deeter's respiratory condition was deteriorating. *Id*. When asked about the presence of clinical pneumoconiosis in the case where the X-ray evidence would be in "equipoise," he responded:

> When one is confronted with an equal number of readings one has to make a decision whether coal worker's pneumoconiosis is present or not, one thing I look at is the amount of exposure to anthracite coal dust. In this case we have 28 and 1/2 years of coal mine employment. It would be more probable than not that coal

[6] The record contains his office notes. CX-20.

> worker's pneumoconiosis would be present in an individual that has 28 and 1/2 years of exposure than not.
>
> In addition, I look at the readers who interpret the films. Doctor Smith has evaluated the X-ray and found it to be positive. I have used Doctor Smith extensively in the care and treatment of my general medical population. I trust his opinion.

CX-19 at 12.

On cross-examination, Dr. Kraynak explained that his opinion was based in part on the fact that Claimant "had to be put on a second inhaler." *Id*. at 13. He sees Claimant about every two months, and acknowledged that Claimant's complaints are non-specific to coal worker's pneumoconiosis. *Id*. at 15. With respect to pulmonary function testing, Dr. Kraynak stated that he had not obtained post-bronchodilator results for his tests because Claimant had been using inhalers, and was effectively already on medicine that had the effect of a bronchodilator.[7] On redirect examination, he explained that the administration of a bronchodilator for a ventilatory study trial, in addition to the medication that had already been proscribed, would result in higher values than would otherwise be obtained. *Id*. at 19.

Dr. Kraynak submitted his final report on July 16, 2003, in which he responded to Dr. Thomas Dittman's deposition testimony. CX-24. He first questioned Dr. Dittman's conclusions with respect to the ventilatory study that Dr. Dittman had administered. He noted that a respiratory technician had conducted this study, and, based on his review of the tracings, "it is clear that the flow loops and tracings show good and complete effort throughout the pre-bronchodilator aspect of the study." The doctor also faulted Dr. Dittman's conclusion that he could exclude the presence of pneumoconiosis:

> Dr. Dittman also stated in his deposition that he was able to exclude the presence of Coal Workers' Pneumoconiosis based upon physical examination. The presence or absence of Coal Workers' Pneumoconiosis is not arrived at by physical examination, rather a review of a chest x-ray or autopsy evidence. Dr. Dittman also notes, on page 28 of his deposition, that it would be unusual for a person with Coal Workers' Pneumoconiosis to have a normal blood gas study at rest, and even more unusual to have a normal blood gas study at both rest and exercise. Blood gases are done to detect a small amount of miners who might have normal pulmonary function, yet may have an inability to oxygenate their blood with exercise. The fact that one has a normal blood gas does not preclude a respiratory disability. In my experience, less than 5% of miners currently receiving benefits have a qualifying blood gas study.

[7] Bronchodilator medicine is designed to improve lung function. *See Hardaway v. Secretary*, *HHS*, 823 F.2d 922 (6th Cir. 1987).

> On page 29 of his deposition, there was a question as to timing of when this study was drawn and when it was run through the machine. Apparently, if the timing is as recorded, there would have been little, if any, exercise induced in Mr. Deeter to see if there was any oxygen desaturation with exercise. Therefore, with these apparent inconsistencies regarding the timing and analysis of the study, the study is suspect and questionable at best.

CX-24. Dr. Kraynak maintained his diagnosis and assessment of totally disabling coal worker's pneumoconiosis. *Id*.

Dr. Thomas H. Dittman

Dr. Dittman is a board certified internist. DX-41 [EX-28]. He submitted a medical report dated April 9, 2003 based on his examination of Claimant on the previous March 28. EX-2. Claimant had reported complaints of worsening shortness of breath for five or six years. Claimant told Dr. Dittman that he suffered dyspnea on exertion when walking two and one-half blocks on level ground, or when he climbs two and one-half flights of stairs. He also reported the presence of a daily productive cough, and some sporadic wheezing. He confirmed to Dr. Dittman that he had never been hospitalized for respiratory reasons. Claimant also reported using a "Flovent metered dose inhaler two inhalations prn for dyspnea" on average once every three weeks. Claimant is a non-smoker.

The doctor recorded a coal mine employment history of 24 years, and also documented that Claimant had worked as a hoisting engineer. Claimant reportedly told Dr. Dittman that he stopped working in 1993 when he began having trouble with his hands.

On physical examination, Dr. Dittman found that the lungs were "[n]ormal to inspection. Normal to palpation. Clear to percussion. No wheezes, rhonchi, rales or rub." The doctor conducted arterial blood gas and pulmonary function testing, and incorporated the interpretation of a chest X-ray — 0/0 — by Dr. Ciotola. He reached the following conclusion with respect to Claimant's respiratory condition:

> ... Respiratory complaints. Mr. Deeter reports that he has had breathing problems for several years. He complains of shortness of breath, dyspnea on exertion, and chronic productive cough. Physical examination of the respiratory system is normal. Arterial blood gases are normal at rest and show a normal response to physical exercise. The chest x-ray does not show evidence of coal workers' pneumoconiosis. Pulmonary function tests were performed with inconsistent and less than maximal effort, thereby making the [test] technically invalid and not useful for actual determination of the patient's lung function.

> It is my opinion that Mr. Deeter does not have coal workers' pneumoconiosis. It is my further opinion that he is not physically impaired or disabled on the basis of coal workers' pneumoconiosis.

EX-2.

Dr. Dittman was deposed on June 6, 2003. EX-10. The doctor described the results of his medical examination of Claimant on March 28, 2003. His report did not indicate that Claimant's lips were cyanotic in appearance, and there were no abnormalities in the chest and lungs. EX-10 at 12. The doctor commented on the ventilatory study that had been conducted for this examination. He acknowledged that he was not present when the test was performed at the Hazleton General Hospital. EX-10 at 15. Nevertheless, by examining the tracings, Dr. Dittman was able to conclude that Claimant's performance in this test was marked by inconsistent and "less than maximum" effort. This produced an invalid test, in Dr. Dittman's view. *Id*. at 17-18. Looking at the arterial blood gas test results, Dr. Dittman observed a "normal pulmonary reserve." *Id*. at 20.

Summarizing his conclusions, Dr. Dittman testified that Claimant does not have coal worker's pneumoconiosis. He reached this opinion based on physical examination and the chest X-ray results. *Id*. at 22. Dr. Dittman rendered the assessment that Claimant does not suffer from a total respiratory disability. He based his opinion upon negative findings on physical examination, and objective tests, including the pulmonary function test results. The doctor concluded: "[p]robably most importantly would be the objective evidence from the arterial blood gasses, which are normal and show a normal response to exercise." *Id*. at 23. He cited the post-exercise increase in the arterial blood gas test result for the PO2. *Id*. at 24.

On cross-examination, Dr. Dittman noted that Claimant has been on an inhaler, but he did not know how long he used it. He acknowledged that Claimant reported using two pillows at night to sleep, and stated that he is a non-smoker. When asked about Claimant's complaints of dyspnea, Dr. Dittman conceded that they would be consistent with coal workers' pneumoconiosis that is "severe enough". *Id*. at 25. He also acknowledged that the values from the ventilatory test, if acceptable, would demonstrate a "moderate lung disease." *Id*. at 26. He clarified his earlier comment with respect to Claimant's lips, which he had said showed no cyanosis, and recalled that his findings were that they were "normal." *Id*. at 28.

Dr. Dittman also allowed that it was "possible" for a patient to be totally disabled by black lung and still have normal resting and exercise blood gas results. The blood gas test results show that the resting sample was drawn at 2:00 p.m., and the exercise sample drawn one minute later. Dr. Dittman saw no reason to discount the results of the arterial blood gas test on those grounds, though he conceded that he was not present when the sample was drawn. *Id at 31*.

Dr. David S. Prince

Dr. David S. Prince reviewed Claimant's ventilatory studies of July 16, 2002 and January 15, 2003, and opined that the degree of impairment shown by those tests would prevent

Claimant's return to his last coal mine employment as a hoisting engineer. CX-4, 14. Dr. Prince is board certified in internal medicine, pulmonary medicine and is a "B reader." CX-5; DX-26.

Dr. Stephen M. Kruk

Dr. Kruk examined Claimant, and rendered his conclusions and findings in a single-page report dated January 15, 2003.[8] CX-8. He recorded complaints of shortness of breath of five years duration, with morning sputum production. Claimant told Dr. Kruk that his breathing is worse in humid weather, and that he can't traverse one to one-half city blocks without having to stop to catch his breath. An attempt to climb one flight of steps gives the same result. Claimant never smoked.

On physical examination, Dr. Kruk noted that Claimant's lungs were "generally clear[.]" There was "[n]o peripheral edema" detected on examination of the lower extremities. Dr. Kruk reviewed the results of a chest X-ray, ventilatory test and a stress test. He concluded:

> I would consider that [Claimant] is totally and permanently disabled secondary to coal worker's pneumoconiosis. This gentleman worked in the mines for over thirty years exposing him to much smoky, dusty air pollution. He was never a cigarette smoker. He has no history of any heart problems. His testing including spirometry, chest x-ray, and stress test reports all show results consistent with coal worker's pneumoconiosis. His prognosis for any improvement in the future is dismal. Again, I would consider him to be totally and permanently disabled secondary to coal worker's pneumoconiosis.

CX-8. Dr. Kruk is board certified in internal medicine. CX-9.

Medical Opinions submitted with original Claim

Dr. Raymond J. Kraynak

Dr. Kraynak examined Claimant on August 11, 1999, and the report of his examination was authored that day. DX-8. He recorded Claimant's personal health history as negative except for arthritis. Mr. Deeter presented with current symptoms of a daily productive cough, and dyspnea on exertion, experiencing shortness of breath after walking two blocks. On physical examination, Dr. Kraynak found no clubbing or edema. An examination of the lungs revealed an increase in the "AP diameter," wheezing on auscultation.

Dr. Kraynak reviewed the results of a chest X-ray, pulmonary function test and an arterial blood gas study. *See* DXs-7, 9 and 10. Based on his examination and clinical data, he diagnosed pneumoconiosis, and opined that Claimant's impairment as a result of this pulmonary condition

[8] Claimant had been referred to Dr. Kruk by Dr. Kraynak to rule out a cardiac etiology to Claimant's "non-specific complaints of shortness of breath, productive cough, and exertional dyspnea." CX-19 (Kraynak Deposition) at 9.

is "moderate [such that he] could not do [last coal mine employment]." The doctor testified at a deposition taken on May 4, 2001. DX-42 [CX-12]. He recalled that Claimant had first came under his care on August 11, 1999. *Id*. at 4. He reviewed the findings that he had presented in his medical report. Dr. Kraynak testified that he had conducted physical examinations throughout his treatment of Claimant. During these examinations, he detected cyanotic lips, indicative of a lowered blood oxygen level, and the lungs showed scattered wheezes. *Id*. at 6. Dr. Kraynak also disputed point by point the criticisms of his pulmonary function testing leveled by Dr. Levinson, stating his disagreement with that expert's view that the tracings varied excessively.

Based on his care and treatment, occupational, social, medical and complaint histories, review of medical records and physical examination, Dr. Kraynak concluded that Claimant suffers from coal worker's pneumoconiosis due to coal mine employment, and "that he has a severe disability relative to this and he would not be able to be further exposed to anthracite coal dust and would not be able to return to his last work in the anthracite coal industry." *Id*. at 12-13.

Dr. Thomas H. Dittman

Dr. Dittman saw Claimant on November 12, 1999, and reported on his examination on November 26. DX-41 [EX-17]. Claimant presented complaints of "breathing problems" for the past three years, with symptoms becoming progressively worse. Mr. Deeter said that he experienced "shortness of breath," with dyspnea on exertion after walking two blocks on level ground or climbing one flight of steps. Claimant also reported to Dr. Dittman having a productive cough, and that he sometimes suffers from some wheezing, usually in the evening. Claimant denied orthopnea, paroxysmal nocturnal dyspnea, and denied any hospitalizations for respiratory reasons.

Dr. Dittman noted a medical history of surgery for carpel tunnel and a herniorrhaphy, as well as a laser procedure for prostate. Past illnesses include arthritis of twenty years duration, but no diabetes, rheumatic heart disease, MI, congestive heart failure, TB or other disorders not relevant. Claimant said he had never smoked. This doctor recorded a coal mine employment history of 24 years in underground mining, with the final three years as a hoisting engineer. Mr. Deeter told the doctor that this work entailed running controls to bring cars up from inside the mine, and that this work was "light" in nature, although he would occasionally assist in lifting and moving mine timbers, a task Claimant thought was "moderately exertional."

On physical examination, Dr. Dittman detected normal lips, and Claimant's lungs were normal to inspection, palpation and clear to percussion with no wheezes, rhonchi, rales or rub. Dr. Dittman also reported the results of arterial blood gas and pulmonary function testing. He noted that during the exercise regimen for the ABG studies, Claimant complained of lightheadedness, and this trial was halted. Doctor Dittman reviewed a chest X-ray that was interpreted by Dr. Joseph Ciotola, who had reported to Dr. Dittman of the absence of any pleural or paranchymal changes consistent with pneumoconiosis. There were no infiltrates, and Dr. Ciotola read the film "0/0." He said this about the pulmonary function testing:

> Pulmonary Function Tests were performed at the Hazleton General Hospital. Spirometry is normal. There is an increase in the MVV in relation to the FEV1 suggesting that there is less than maximum effort for the MVV. The tracings for the MVV confirm this.

DX-41 [EX-17] page 4.

He reached the following conclusions with respect to Claimant's respiratory condition:

> ... Respiratory complaints. Mr. Deeter complains of having problems with his breathing for 3 years. He complains of shortness of breath, dyspnea on exertion, chronic cough, intermittent wheezing. The physical examination of the respiratory system is unremarkable. Arterial Blood Gases are normal. Pulmonary Function Tests are normal. Chest x-ray does not show evidence of pneumoconiosis.
>
> It is my medical opinion that Mr. Deeter does not have coalworker's pneumoconiosis and is not physically impaired nor disabled on the basis of coalworker's pneumoconiosis.

Id.

Dr. Dittman was deposed on February 16, 2001, and testified about the procedures he used to conduct his physical examination, and his conclusions about Claimant's condition. DX-41 [EX-26] at 9-16. The doctor also testified about conclusions he drew from his review of additional medical records. Dr. Dittman opined that the arterial blood gas study administered by Dr. Kraynak on August 11, 1999, demonstrated a "normal response to exercise." DX-41 (Dittman Deposition) at 17. Addressing Dr. Kraynak's pulmonary function study, he pointed out what he considered to be a "great variability between the tracings and there's also evidence of lack of maximum effort for the testing." DX-41[EX-26] at 17.

Based on his review of these records, and from the results of his own clinical testing and physical examination, Dr. Dittman concluded that Claimant does not suffer from coal workers' pneumoconiosis or any other coal mine dust related pulmonary disease. In his opinion, Claimant is neither partially nor totally disabled or impaired due to any coal mine dust related pulmonary disease. *Id*. at 19. He explained:

> Certainly the physical examination and the diagnostic studies, particularly the arterial blood gases which are normal and the pulmonary function tests which are normal. The chest x-ray has been interpreted by many physicians as being negative for pneumoconiosis, by some as being positive so there may be some

> conflict of opinion in that regard, but in my opinion the patient still does have pneumoconiosis and is not impaired.[9]

Id. at 20.

Dr. Dittman also contended that, even assuming Claimant suffered from pneumoconiosis, he was not totally or permanently disabled from a coal dust related pulmonary condition. *Id*. at 21. On cross-examination, the doctor said that, from an overall medical view, Claimant would be able to return to his last coal mine employment, although he confirmed that Claimant's rheumatoid arthritis would pose a problem. He admitted that he had not inquired about the "physical ergonomics" of Claimant's last coal mine work. *Id*. at 23. He agreed that Claimant "potentially" has a significant exposure to anthracite coal and rock dust, and that the nature of the complaints that Claimant provided were consistent with pneumoconiosis.

On further cross-examination, Dr. Dittman elaborated on the medical factors that he would expect to find in a miner afflicted with pneumoconiosis, including hyperinflation and use of the accessory muscles for breathing. He acknowledged that a miner with simple pneumoconiosis would probably have a "normal exam on palpation [of the lungs]." *Id*. at 24-25. He also conceded that one would not normally detect hyperresonance on examination, and that the absence of wheezes, rales, rhonchi or rub would not preclude the presence of a disabling coal workers' pneumoconiosis. *Id*. at 25. He also opined that it would be rather unusual that a person could be disabled or impaired by pneumoconiosis and still generate normal blood gas studies. He did not rule out this possibility, however.

Dr. David S. Prince

Dr. David S. Prince examined pulmonary function studies administered in this claim. After reviewing tracings, he concluded in a letter dated May 10, 2001, that the August 11, 1999, test represented "sufficient respiratory impairment to preclude employment as a hoisting engineer." DX-42 [CX-13].

Pulmonary Function Studies submitted on Modification

Pulmonary function studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). These studies may also constitute evidence of a totally disabling pulmonary or respiratory impairment, when evaluated at 20 C.F.R. § 718.204(b)(2)(i).

The record contains results from the following pulmonary function studies, along with the reports of medical experts who reviewed the tests and their associated tracings. I must consider the opinions of consulting experts who have reviewed the performance tracings of these studies to determine the appropriate weight to be assigned to the results of each test. The Third Circuit has emphasized that the administrative law judge "must determine whether the test results meet the quality standards and whether the medical evidence is reliable[.]" *Siwiec*, 894

[9] From the context of his deposition testimony and medical report, it is apparent that Dr. Dittman's opinion is that Claimant does not suffer from pneumoconiosis.

F.2d at 638. *See generally*, *Director*, *OWCP v. Mangifest*, 826 F.2d 1318, 1325-26, 10 BLR 2-220 (3d Cir. 1987). In assessing the weight of clinical tests, I must compare the medical qualifications of both administering and consulting physicians in determining the probative value of their opinions. *See Worley v. Blue Diamond Coal Co.*, 12 BLR 1-20 (1988).

Pulmonary Function Study. Dr. Kraynak. July 16, 2002.

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
DX 53	07-16-2002	63	73"	1.24	3.46	48.81	35.76%	Yes

Dr. Kraynak viewed Claimant's cooperation, comprehension and effort in the performance of this study as "good." Tracings accompany this test. Dr. Kraynak's impression was that this test indicated a "severe restrictive defect."

Dr. Sander J. Levinson reviewed the test and in his report of August 5, 2002 stated that it was "not acceptable," because it was performed with less than optimal effort, cooperation and comprehension. He explained that the "[e]xhalation has not been preceded by maximal inhalation[.] Pt has not used maximal effort throughout FVC attempt[.] Has obviously held back in course of exhalation." DX-54. Dr. Levinson is board certified in internal medicine, with certification in the sub-specialty of pulmonary disease. Id.

In his report of February 3, 2003, Dr. Kraynak disputed Dr. Levinson's critique, and asserted that Claimant's "inhalation was excellent and maximal[,]" and that there was "good effort given throughout." Dr. Kraynak, cited his "review of the tracings [and ...] his physical observation of [Claimant] performing the test[,]" and disagreed with Dr. Levinson's opinion that Claimant "held back" in his performance. CX-1. Dr. Kraynak restated his disagreement with Dr. Levinson's conclusions in his deposition testimony, taken on May 9, 2003. CX-19 at 7. Dr. Prince reviewed this test and in his report of April 21, 2003 concluded that it was a valid study, as demonstrated by "uniform, consistent, and reproducible" trials. CX-14.

I accord more weight to Dr. Prince's opinion regarding the validity of this test over the conflicting review by Dr. Levinson. I note in particular Dr. Prince's credentials as a board certified internist, with certification in pulmonary medicine. Moreover, Dr. Prince's opinion is supported by Dr. Kraynak, who administered the exam. More weight may be given to the observations of the technician who administers a pulmonary function study than to a doctor who reviewed the tracings. Revnack v. Director, OWCP, 7 B.L.R. 1-771 (1985). I find that this is a valid study.

Pulmonary Function Study. Dr. Stephen Kruk. January 15, 2003.

Ex. No.	Date	Age	HT	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
CX 2	01-15-03	63	73"	1.98	2.59	58.28	76.56%	Yes

Dr. Kruk observed that Claimant's cooperation, comprehension and effort in the performance of this study was "good." Dr. Kruk's impression was that this test indicated a "restrictive defect." Dr. Prince reviewed the study and found it valid. In his report of March 24,

2003, Dr. Prince explained that the test conformed with the regulations and said that the tracings were "uniform, consistent and reproducible." CX-4. This study was also reviewed by Dr. C. Vaughn Strimlan. In a letter report, Dr. Strimlan opined that "the tracings revealed good effort and cooperation." CX-11. He explained that there "appear to be comparable and reproducible forced vital capacity maneuvers." This expert concluded:

> The study is consistent with a severe restrictive pulmonary ventilatory pattern. I would consider this a valid study for the purpose of pulmonary impairment evaluation. It appears to conform with the Federal Black Lung guidelines.

CX-11. Dr. Strimlan is board certified in internal medicine, and certified in the subspecialty of pulmonary disease. He is also an "A reader" of X-rays. CX-13.

Dr. Sander J. Levinson reviewed the tracings from this test on May 13, 2003. EX-4. He considered this to be an invalid study, citing subpar effort, cooperation and comprehension and "improper performance." He explained:

> There is a significant gap between the inspiration and exhalation suggesting that exhalation has not been preceded by a maximal inspiration. The inspiration has been carried into the negative volume indicating that the patient has begun to exhale prior to its being recorded on the graphic curve or calculated by the amounts indicated for the FEV1 and forced vital capacity. The effort expended by the patient is clearly unacceptable because there is a gross and excessive variability between the FEV1s' of the two largest attempts. These FEV1s' vary by 230 mls. which exceeds the 718 Regulations indicating that the FEV1 should not vary by more than 100mls. or 5% of the largest FEV1. The MVV curves indicate a variable and inconsistent effort so that the patient has not exerted a maximal and sustained effort for 12 to 15 seconds as required.

Dr. Kraynak disagreed with Dr. Levinson's opinion that a gap appeared between inhalation and exhalation. Dr. Kraynak did not detect an exhalation occurring before a recordation on the graph paper. Dr. Kraynak continued:

> [Dr. Levinson] states there was excessive variability with the efforts, by 230 ml. From my review, the two largest FEV1s vary be less than 85 ml, corresponding to the regulations. [Dr. Levinson] also states the MVV curves are variable and inconsistent of effort, and do not continue for twelve to fifteen seconds. From my review, they show good effort throughout and approach the percentage of predicted of the FEV1, corresponding to excellent effort. ... From my review, the tracings continue for twelve seconds and show good and consistent effort.

CX-22.

I am mindful of Dr. Levinson's detailed critique and his qualifications. Nevertheless, I find that the opinions of Drs. Prince and Strimlin are better reasoned and consistent, and entitled to more weight. I find this study to be both in substantial compliance with applicable criteria and reliable.

Pulmonary Function Study. Dr. Kraynak. March 20, 2003.

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**
CX 3	03-20-2003	63	73"	2.06	2.84	71.01	72.38%	Yes

Dr. Kraynak concluded that the results of this test demonstrated "severe restrictive defect". The doctor deemed Claimant's cooperation, comprehension and effort in the performance of this study to be "good." Dr. Strimlan concluded that "the tracings revealed good effort and cooperation." He explained that there "appear to be comparable and reproducible forced vital capacity maneuvers." Dr. Strimlan found the test to be a "valid study" for the evaluation of pulmonary impairment, and that it appears to conform to Federal Black Lung guidelines. CX-12.

I find that this test is in substantial compliance with the applicable regulations and is reliable.

Pulmonary Function Study. Dr. Dittman. March 28, 2003.

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**
EX 2	03-28-2003	63	71"	1.78	2.43	51.14	0.73	Yes
(post bronchodilator)				2.31	3.11	61.14	0.74	No

Dr. Dittman commented that Claimant's "effort for testing is inconsistent and less than maximum. This will falsely lower the results obtained and reduce the reliability for the testing for accurate determination of actual lung function." He found that the test produced "[r]esults which… might suggest moderate obstructive and restrictive defect with significant improvement after bronchodilator. Patient's reduced effort, however, for the study must be considered." I accord significant weight to Dr. Dittman's uncontroverted opinion, and find that the test is in substantial compliance with the Secretary's regulations. However, I note that because of Claimant's reduced effort, the probative value of the test is reduced.

Pulmonary Function Studies submitted with the Original Claim

Pulmonary Function Study. Dr. Raymond J. Kraynak. August 11, 1999.

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**
DX 7	08-11-1999	60	72"	2.97	3.80	65		No
(post bronchodilator)				2.42	3.43	67		No

Dr. Kraynak interpreted this study as showing a "severe air flow defect." This test was reviewed by Dr. Jonathan Hertz on February 26, 2001. DX-41 [EX-20]. He opined that:

> [S]pirometry curves do demonstrate excessive variability between the 3 acceptable curves. The variation between the 2 largest FEV1s is 1.2 liters, which is clearly much greater than 5% of the largest FEV1, of 100 ml., dictated by Part 718 Regulations. The spirometry tracings are also very irregular, and demonstrate that the patient has not used maximal effort during the entire forced expiration. For these reasons, I find that the pulmonary function testing ... is invalid, and does not comply with Part 718 Regulations.

DX-41 [EX-20]. Dr. Hertz is board certified in internal medicine and pulmonary disease, and is certified as a "B-reader" of X-rays. In addition, his resume lists experience as a "Clinical Assistant Professor of Medicine" at the College of Medicine, Pennsylvania State University. DX-41 [EX-28]. Dr. Kraynak responded to this review in a letter report, dated March 12, 2001. Dr. Kraynak disagreed with Dr. Hertz's view that the two largest FEV1s vary by less than 85 ml, and said that the tracings were "very uniform and show good effort throughout." DX-42 [CX-12].

Dr. Dittman reviewed this study, and testified at deposition pointed out what he considered to be a "great variability between the tracings and there's also evidence of lack of maximum effort for the testing." DX-41 (Dittman Deposition) at 17. Dr. Kraynak, in a March 12, 2001 letter report, disputed Dr. Dittman's interpretation of the tracings. He emphasized that he did not detect the variability that had been discerned by Dr. Dittman. DX-42 [CX-12].

Dr. David S. Prince examined this study's tracings, and concluded in a letter dated May 10, 2001, that the "volume time curves it is clear that the reported values represent [Claimant's] maximal ventilatory capabilities." He further opined that this test represents "sufficient respiratory impairment to preclude employment as a hoisting engineer." DX-42 [CX-13].

Upon consideration of the conflicting medical opinion reviews of this study, I find that this test is not in substantial compliance with the Secretary's regulations. I note that the opinion of Dr. Prince, who holds similar credentials to those of Employer's experts, is buttressed by the opinion of Dr. Kraynak, who administered the study. However, I accord greater weight to the more detailed explanations of Employer's well credentialed experts and find that they are more persuasive.

Pulmonary Function Study. Dr. Kraynak. November 11, 1999.

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**
DX 42	11-11-1999	60	72"	1.93	3.84	34	0.70	Yes

Dr. Kraynak viewed Claimant's cooperation, comprehension and effort in the performance of this study as "good." Dr. Kraynak's impression was that this test indicated a "severe air flow defect." Dr. Sander J. Levinson reviewed this study and found it invalid. In his report of March 20, 2001, Dr. Levinson explained:

> First, I feel that the study has been improperly performed and I do not feel that the entire forced vital capacity curves have been displayed. There is evidence of exhalation occurring before the zero point so that the results reported as the FEV1 and forced vital capacity do not represent the true and complete capacities ... but are rather an underestimation. Furthermore, the effort expended by the patient is clearly unacceptable. There is a gross and excessive variability of the FEV1' of the two largest attempts. These FEV1s' vary by 875mls. which greatly exceeds the 718 Regulations indicating that the FEV1 should not vary by more than 100mls. or 5% of the largest FEV1. The MVV curves indicate a variable and inconsistent effort for a period of only 10 ½ seconds so that the patient has not exerted a maximal and sustained effort for 12 to 15 seconds as required.

DX-41 [EX-27].

I accord greater weight to the opinion of Dr. Levinson as better reasoned. I also find that his superior credentials entitle his opinion to some additional weight. I find that this test is not in substantial compliance with the applicable criteria.

Pulmonary Function Study. Dr. Dittman. November 12, 1999.

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**
DX 41	11-12-1999	60	71"	3.00	3.85	77.82	0.78	No
(post bronchodilator)				3.12	3.65	100.86	0.85	No

Notations on the test indicate "good patient cooperation and effort", and Dr. Dittman noted "normal spirometry." This test was reviewed by Dr. David S. Prince. In his report, dated January 19, 2000, Dr. Prince concluded that this study was valid. On February 24, 2001, Dr. Prince submitted another review, indicating that this test was not acceptable because the tracings did not meet the criteria that they include "expiration for at least 5 sec. or until obvious plateau." DX-42 [CX-6]. Dr. Robin L. Kaplan reviewed this test. DX-41 [EX-18]. In his February 20, 2001 consultation report, Dr. Kaplan opined:

> While this test is technically not valid due to insufficient duration of effort on each forced expiration, the actual results are nearly normal. Therefore, in my opinion these results are valid despite the deviation from the Part 718 criteria, and it is inappropriate to reject these results on the basis of this single technical deficiency. A major reason for applying Part 718 criteria is to insure that

> abnormal results of pulmonary function testing are indicative of real clinical pathology and not the result of non-clinical factors, such as submaximal effort, etc. ... [T]he results of the Hazleton General Hospital test are normal in spite of the Claimant's submaximal effort.

Dr. Kaplan is board certified in internal medicine and pulmonary medicine. DX-41 [EX-28]. Dr. Kraynak reviewed Dr. Kaplan's comments, and agreed that this study was not valid because of "frequent breaks within the flow loops, corresponding to technical problems." DX-42 [CX-12]. In his deposition, Dr. Kraynak opined that, with technical irregularities in the test's flow loops, the study "is unreliable and you can't put any weight on it." DX-42 [CX-12] at 11. Dr. Jonathan Hertz also reviewed this pulmonary function study, and in his report dated February 26, 2001, concluded that the study results were within normal limits, but that the study does not comply with Part 718 and is invalid. Dr. Hertz explained:

> The spirometry tracings are irregular, and show some hesitation, demonstrating that the patient did not use maximal effort during the entire forced expiration. Nevertheless, the spirometry measurements ... are within normal limits, and demonstrate that [Claimant] has normal pulmonary reserve. Despite his lack of optimal effort during the spirometry attempt, this could not falsely elevate his pulmonary function testing or falsely demonstrate this satisfactory pulmonary reserve. ... [T]his test does demonstrate that [Claimant] does have pulmonary functions which are within the range of normal limits.

DX-41 [EX-19]. Dr. Hertz is board certified in internal medicine and pulmonary disease, and is certified as a "B-reader" of X-rays. In addition, his resume lists experience as a "Clinical Assistant Professor of Medicine" at the College of Medicine, Pennsylvania State University. DX-41 [EX-28]. In his letter report dated March 12, 2001, Dr. Kraynak agreed with Dr. Hertz's view that this test is not valid, because there was "irregularity, hesitation and technical problems throughout the course of the study. This study would not have any value in assessing Mr. Deeter's pulmonary condition." DX-42 [CX-12].

Dr. Sander J. Levinson reviewed this study on February 28, 2001, and opined that this study was valid. DX-41 [EX-21]. Dr. Levinson is board certified in internal medicine, and in the sub-specialty of pulmonary disease, and is certified as an "A- reader" of X-rays. EX-9. His credentials include an appointment as an "Assistant Professor of Medicine," Temple University School of Medicine. DX-41 [EX-28]. This test was also reviewed by Dr. John P. Simelaro, who, in a February 17, 2000 report, considered this test not to be acceptable because "tracing less than 5 sec." Dr. Simelaro is board certified in internal medicine. DX-42 [CX-8, 10]. Dr. Michael A. Venditto considered this test unacceptable, because the tracings did not extend for the requisite 5 seconds. Dr. Venditto is board certified in internal medicine, and certified as a specialist in diseases of the chest. DX-32 [CX-9, 11].

I find that the evidence regarding this test demonstrates that it is not in substantial compliance with the applicable regulations. Despite opinions suggesting that it reflects Claimant's pulmonary function, I find it of little probative value in assessing the nature and extent of Claimant's disability, and accord it little weight.

Arterial Blood Gas Study Evidence submitted on Modification

Arterial blood gas studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). These studies may also constitute evidence of a totally disabling pulmonary or respiratory impairment, when evaluated at 20 C.F.R. § 718.204(b)(2)(ii). An arterial blood gas study administered by Dr. Dittman on March 28, 2003 was submitted on modification, with non-qualifying results showing pCO2 of 35 before exercise and 37.6 after; pO2 of 83.2 before exercise and 94.1 after. EX-2.

Dr. Dittman remarked that the results demonstrated that "[b]efore exercise ― oxygenation is normal. Acid/base balance is normal. After exercise ― Oxygenation is normal. Acid/base balance is normal." He considered the arterial blood gas study results as indicative of a "normal response to physical exercise." I accord substantial weight to this opinion and find that newly submitted arterial blood gas study is not qualifying.

Arterial Blood Gas Studies submitted with the Original Claim

Arterial Blood Gas Study. Dr. Kraynak. November 12, 1999.

Ex. No.	Date	Alt.	pCO2	pO2	Qualify
DX 9	08-11-1999	0.2999	39	74	No
	(exercise)		39	107	No

Arterial Blood Gas Study. Dr. Dittman. November 12, 1999.

Ex. No.	Date	Alt.	pCO2	pO2	Qualify
DX 41	11-12-1999	?	39	86	No
	(exercise)		43	81	No

Dr. Dittman remarked that the results demonstrated that "oxygenation is normal" both before and after exercise. Acid balance was also deemed "normal."

Dr. Kraynak commented on this test during his deposition testimony. DX-42 [CX-12] at 9. He noted that, while the values were within the "normal" criteria, he disagreed that oxygenation was normal because of the post-exercise drop of the pO2.

I find that these tests are in substantial compliance with the Secretary's regulations, and are non-qualifying.

Miscellaneous Medical Records

Employer submitted medical records from Dr. Lupold and the Pottsville Hospital. DX-41 [EX-23]. The records show that Claimant had been hospitalized at the Pottsville Hospital on May 11, 1998 for a prostate procedure. The discharge summary, dated May 12, contains the results of a physical examination by Dr. Richard A. Greco, a certified urologic surgeon. Dr. Greco reported that an examination of the lungs "[r]evealed good aeration bilaterally with no rales or wheezing." An examination of Claimant's lungs conducted on May 6 revealed "[n]ormal breath sounds throughout both lung fields."

E. Elements of Entitlement

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, as set forth at 20 C.F.R. § 718.202(a)(1) through (4):

A. X-ray evidence. Section 718.202(a)(1).

B. Biopsy or autopsy evidence. Section 718.202(a)(2).

C. Regulatory presumptions. Section 718.202(a)(3).

1. Section 718.304 ― Irrebuttable presumption of total disability due to pneumoconiosis is there is evidence of complicated pneumoconiosis.

2. Section 718.305 ― Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner had proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

3. Section 718.306 ― Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

D. Physician's opinions based upon objective medical evidence. Section 718.202(a)(4).

The Third Circuit has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 25, 21 BLR 2-104 (3d Cir. 1997).

Discussion

X-ray Evidence pursuant to § 718.202(a)(1)

Claimant may initially demonstrate the existence of pneumoconiosis on the basis of X-rays which are interpreted as positive for the disease under the classification standards set forth at 20 C.F.R. § 718.102(b) (2000) as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. *See Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999) (*en banc* on recon.).

Upon consideration of the newly submitted X-ray evidence, I find that Claimant has demonstrated the presence of pneumoconiosis at Section 718.202(a)(1). Two chest X-rays were interpreted as "positive" by three radiologists. The first, taken on March 20, 2003, was reread as negative by a single radiologist. The second film, taken eight days later on the 28th, was reread as negative by three of Employer's experts.

I find that the first of these films is clearly positive for the disease. The preponderance of the readings, all by dually qualified radiologists, demonstrates that this X-ray shows pneumoconiosis. The second film has six conflicting interpretations by radiologists with equally impressive qualifications ─ three each for either the presence or absence of the disease. I find that this film is not persuasive evidence of the presence of pneumoconiosis because the evidence is in equipoise.

I find that the X-ray evidence submitted in 1999 with the original claim does not demonstrate the presence of pneumoconiosis, based on the negative readings of these films by Drs. Scott and Wheeler, whose dual credentials as board certified B-readers are buttressed by the most impressive and long-term academic qualifications of record. Accordingly, I find no mistake in the determination of a fact in the prior adjudication with respect to the X-ray evidence.

Because the X-ray evidence submitted on modification is positive for the presence of pneumoconiosis, Claimant has established a change in conditions with respect to this type of evidence.

Biopsy or Autopsy Evidence pursuant to 20 C.F.R. § 718.202(a)(2)
Applicable Presumptions

Claimant cannot demonstrate pneumoconiosis at Section 718.202(a)(2), because the record contains no evidence relevant to that provision. He is also precluded from the presumptions accorded under Section 718.202(a)(3), because there is no evidence of complicated pneumoconiosis. The presumptions set forth at Sections 718.305 and 718.306 are foreclosed because this claim was filed after January 1, 1982.

Medical Opinion Evidence pursuant to 20 C.F.R. § 718.202(a)(4)

The medical opinion evidence on modification consists of the reports of Drs. Dittman, Kraynak and Kruk. Dr. Dittman concludes without equivocation that Claimant does not suffer

from the disease. Dr. Kraynak offers a contrary view, and his diagnosis is supported by the medical opinion of Dr. Kruk. For the following reasons, I am more persuaded by the opinions of Claimant's experts.

I find that Dr. Kraynak's recent opinion is better supported by documentation overall, and that his conclusions are better reasoned. A "reasoned medical opinion rests on documentation adequate to support the physician's conclusions." *Migliorini v. Director, OWCP*, 898 F.2d 1292, 1295, 13 BLR 2-418 (7th Cir.), *cert. denied*, 498 U.S. 958 (1990). *See Clark v. Karst-Robbins Corp.*, 12 BLR 1-149 (1989) (*en banc*); *Tackett v. Cargo Mining Co.*, 12 BLR 1-11 (1988) (*en banc*). The X-ray upon which he has relied has been found to be a "positive" film. Although I may not disregard Dr. Dittman's medical opinion simply because it is based in part on a chest X-ray that I consider to be "inconclusive," I accord more weigh to the opinions of Drs. Kraynak and Kruk, whose findings rely upon positive X-ray results.

Moreover, Dr. Kraynak's opinions are supported by, and consistent with, the more recent, and valid, pulmonary function testing. Ventilatory tests are cited as acceptable documentation for a reasoned medical opinion at Section 718.202(a)(4). Of the ventilatory tests introduced for consideration on modification, three tests have been found to be reliable, and produced results that qualify under disability criteria. Although Dr. Dittman questioned the results of his March 28, 2003, study, EX-2, he did state that the test "[r]esults generated might suggest moderate obstructive and restrictive defect with significant improvement after bronchodilator. Patient's reduced effort, however, must be considered." I accord greater weight to Dr. Kraynak's opinion regarding Claimant's effort, as he administered the test. CX-19 (Kraynak Deposition) at 10.

Although Dr. Dittman has superior credentials than Kraynak, I find that Dr. Kraynak's opinion is better reasoned. In addition, Dr. Kraynak's opinion is consistent with that of Dr. Kruk, who is a board certified internist. I have considered Dr. Kraynak's relationship to Claimant as treating physician, and the nature of that relationship regarding its duration and the frequency and extent of treatment. 20 C.F.R. § 718.104(d)(1) - (4). Although I find the record insufficient to accord Dr. Kraynak's opinion controlling weight, I find his status entitles his opinion to additional weight, particularly because it is well documented and reasoned.

According greater weight to the opinions of Drs. Kraynak and Kruk, I find that Claimant has demonstrated that he suffers from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). I have considered the opinions and credentials of Dr. Dittman, who examined Claimant on multiple occasions. I have also accounted for the medical examination during Claimant's 1998 hospitalization, in which Dr. Richard A. Greco reported that an examination of the lungs "[r]evealed good aeration bilaterally with no rales or wheezing[,]" and that a further examination revealed "[n]ormal breath sounds throughout both lung fields." Considering the medical opinion evidence as a whole, I find that the preponderance of the medical opinions that were submitted in conjunction with the original claim do not prove the existence of pneumoconiosis. Accordingly, I find no mistake in the determination of fact regarding the medical opinion evidence in the prior adjudication.

Considering the all of the evidence, like and unlike, together, I find that Claimant has established the presence of pneumoconiosis. According, Claimant has demonstrated a change in condition.

2. Pneumoconiosis – Causality

Claimant must show that his pneumoconiosis arose out of his coal mine employment. Section 718.203(b) provides for a presumption of causality "[i]f a miner who is suffering ... from pneumoconiosis was employed for ten years or more in one or more coal mines[.]" 20 C.F.R. § 718.203(b). Claimant worked in coal mine employment for 28 ½ years, and therefore is entitled to the presumption. Claimant has established that his pneumoconiosis arose out of his coal mine employment.

3. Total Respiratory Disability

Claimant must demonstrate that he is totally disabled due to pneumoconiosis in order to be eligible for benefits under the Act. The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. I must weigh all of the relevant probative evidence which meets one of the four standards applicable to living miners under Section 718.204(b)(2). *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986). In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish Claimant's total disability. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987).

The question of whether Claimant is totally disabled was not squarely addressed in the prior decision in this case because Claimant was found not to have established the existence of pneumoconiosis. The determination of whether Claimant has established total respiratory disability in any event shall be made based on a consideration of the record as a whole. I note, however, that more recent reports may be more probative of the disability opinions of record, because the nature and extent of any disability is judged for a miner's condition at the time of the hearing. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 624, 11 BLR 2-147 (6th Cir. 1988); *see also Coffey v. Director, OWCP*, 5 BLR 1-104 (1982).

According to § 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis, and 4) a reasoned medical opinion concluding total disability. 20 C.F.R. § 718.204(b)(2)(i) - (iv).

Pulmonary Function Studies at 20 C.F.R. § 718.204(b)(2)(i)

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, accounting for sex, age, and height, produce a qualifying value for the FEV1 test, plus either a qualifying value for the FVC test, or the MVV test, or a value of FEV1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV1, FVC and the MVV tests are measured results less than or equal to the values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718. 20 C.F.R. § 718.204(b)(2)(i). *Siwiec*, 894 F.2d at 636, 637 n. 5.

There are seven ventilatory tests in evidence. I have found that two of the three tests submitted with the original claim are not in substantial compliance with the Secretary's regulations, and are entitled to less weight. DXS-41, 42.

The more recent pulmonary function study evidence demonstrates a deterioration in Claimant's pulmonary function. Claimant performed four tests between July 16, 2002 and March 28, 2003. DX-53, CXs-2,3, EX-2. The first three tests, administered without a bronchodilator, produced qualifying results. The last test, administered by Dr. Dittman, yielded qualifying figures for the pre-bronchodilator trial, and non-qualifying results for the regimen on that medication.

I find that Claimant has demonstrated total respiratory disability on the strength of the overall pulmonary function testing results. I have carefully considered the opinions of all physicians and their credentials, and find that the newly submitted qualifying tests are entitled to greater weight. The newly submitted pulmonary function tests demonstrate that Claimant is disabled, and also demonstrate a change in condition.

Arterial Blood Gas Studies at 20 C.F.R. § 718.204(b)(2)(ii)

There is no record evidence of qualifying arterial blood gas studies. Therefore, I find that Claimant has failed to demonstrate total respiratory disability at Section 718.204(b)(2)(ii) on the basis of this evidence, and has failed to demonstrate a change in condition.

Cor Pulmonale Diagnosis at 20 C.F.R. § 718.204(b)(2)(iii)

A claimant may demonstrate total disability with medical evidence of cor pulmonale with right-sided congestive heart failure in addition to pneumoconiosis. There is no evidence of cor pulmonale with right-sided congestive heart failure. 20 C.F.R. § 718.204(b)(2)(iii). Claimant has therefore not demonstrated total respiratory disability at this Section. *See Newell v. Freeman United Coal Mining Co.*, 13 BLR 1-37 (1989), *rev'd on other grounds*, 933 F.2d 510, 15 BLR 2-124 (7th Cir. 1991).

Medical Opinion of Disability at 20 C.F.R. § 718.204(b)(2)(iv)

A miner may demonstrate total respiratory disability by a reasoned medical opinion, which concludes that he is totally disabled, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. A Claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual coal mine employment or comparable and gainful employment." 20 C.F.R. § 718.204(b)(2)(iv). Any loss in lung function may qualify as a total respiratory disability under Section 718.204(b)(2). *See Carson v. Westmoreland Coal Co.*, 19 BLR 1-16 (1964), *modified on recon*., 20 BLR 1-64 (1996). *See generally Beatty v. Danri Corp*., 49 F.3d 993, 19 BLR 2-136 (3d Cir. 1995).

Upon consideration of the medical opinion evidence, I find that Claimant has established that he suffers from a totally disabling pulmonary or respiratory impairment. My analysis of the relative strengths of the medical opinions at Section 718.202(a)(4) applies as well to my

credibility determinations at Section 718.204(b)(2)(iv). I have found that, on this record, the more recent opinions of Dr. Kraynak are better documented, and his diagnosis of pneumoconiosis and assessment of total disability better reasoned. First, his conclusions are supported by those of Dr. Kruk and, to a lesser extent, by Dr. Prince, who opined that the results of pulmonary function testing demonstrated Claimant's inability to return to his usual coal mine work. CX-4, CX-14, DX-42 [CX-13]. Dr. Kraynak's assessment is also supported by pulmonary function testing, physical examinations, a relatively long term treatment relationship, and well-reasoned explanations.

Accounting for Dr. Dittman's credentials, his findings on physical examinations, and both pulmonary function and arterial blood gas testing, I nevertheless find that Claimant has demonstrated total respiratory disability at Section 718.204(b)(2)(iv). I note that the doctor was unfamiliar with the exertional requirements of Claimant's coal mine employment.

Total Disability – Conclusion

The adjudicator is required to review all relevant evidence, like and unlike, to determine whether a claimant has established total respiratory disability. *See Shedlock v. Bethlehem Mines Corporation*, 9 BLR 1-195 (1986), *aff'd on recon. en banc*, 9 BLR 1-236 (1987). The fact that the arterial blood gas tests yielded non-qualifying results, and all of Dr. Dittman's opinions that Claimant is not totally disabled, consist of contrary probative evidence that I have duly noted. On balance, given the medical opinions by Drs. Kraynak, Kruk, the brief letter reports by Dr. Prince, the more recent ventilatory testing, as well as Claimant's testimony regarding his breathing problems and the physical requirements of his last coal mine work as a hoisting engineer, *see Fields v. Island Creek Coal Company*, 10 BLR 1-19 (1987); *see also Madden v. Gopher Mining Company*, 21 BLR 1-122 (1999), I find that Claimant has established the element of total respiratory disability. 20 C.F.R. § 718.204(b)(2). I am mindful that Claimant had described his work as a hoisting engineer to Dr. Dittman as "light." Nevertheless, having observed Claimant's testimony, which I find to be credible, and assessing the medical opinions of record, I find that he has established total respiratory disability.

4. Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c). Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to his total respiratory disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989).

I find that Claimant has satisfied his burden of proving disability causation on the basis of the medical opinions of Dr. Kraynak and Dr. Kruk, who concluded that Claimant's respiratory disability was due to his coal workers' pneumoconiosis. Claimant is a non-smoker, and no medical opinion offers an alternate etiology for his disabling pulmonary or respiratory impairment. While the absence of an alternate cause does not entitle a claimant to a causation finding as a matter of default, it strengthens the causation opinions of Dr. Kraynak and Kruk, who attribute Claimant's total respiratory disability to coal workers' pneumoconiosis.

In view of the opinions by Claimant's experts, and having reviewed the contrary opinions from Dr. Dittman, I find that Claimant has established that coal workers' pneumoconiosis is a substantial contributor to his total respiratory disability.

CONCLUSION

Claimant has established that he is totally disabled due to pneumoconiosis. Claimant also has established a change in condition. Based on the foregoing, Claimant has established entitlement to benefits.

COMMENCEMENT OF BENEFITS

As I have found that Claimant is totally disabled due to pneumoconiosis arising out of his coal mine employment, he is entitled to black lung benefits. Benefits are payable to a miner who is totally disabled due to pneumoconiosis beginning with the month of onset of disability. Where onset cannot be determined, benefits commence with the date the claim was filed. § 725.503(b). I find that the evidence of record does not establish the date of onset of Claimant's disability. Therefore, benefits shall commence as of July, 2002, the month and year in which the claim was filed.

ATTORNEY'S FEE

No award of attorney's fees for services to Claimant is made herein because no fee application has been received. Thirty (30) days is hereby allowed Claimant's counsel for the submission of a fee application which must conform to §§ 725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties including Claimant must accompany the application. Parties have ten (10) days following receipt of any such application within which to file any objection. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of RICHARD F. DEETER for benefits under the Act is AWARDED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, DC 20210.